

Dublin Dental School and Hospital

ORAL & MAXILLOFACIAL SURGERY

REFERRAL LETTER

Yes No

Concern re Oral / Head & Neck Cancer

Consultant / receiving practitioner and/or specialty clinic

Hospital and Hospital address

DATE:

REFERRAL TO

Department of Oral & Maxillofacial Surgery

Dublin Dental School and Hospital Lincoln Place, Dublin 2.

Or email to patient@dental.tcd.ie

PATIENT DETAILS

Patient’s address

Surname

Forename(s) Previous Surname

Telephone no.

Sex

M

F

Or Contact

Age

Date of Birth

E-Mail

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REFERRING PRACTITIONER DETAILS

Practice address

Name

Email address Telephone no.

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REGISTERED GP DETAILS (Medicine)

Practice address

Name

Email address Telephone no.

CLINICAL INFORMATION

**Please complete all sections to facilitate appropriate triage of your referral.  Proformas with insufficient detail will be returned for completion**

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| **History of presenting complaint/ examination findings/ investigation results** | | | | | |
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| **Reason for referral** | | | | | |
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| **Past Medical History** | | | | | |
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| **Current and recent medication** | | | | | |
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| **Clinical warnings (*e.g. allergies, blood-borne, viruses)*** | |  |  | Smoking status | Alcohol consumption |
|  | | No per day | Duration |  |  |
|  | |  |  |  |  |
|  | |  | Ever Smoked | Yes | No |
|  | |  |  |  |  |
| Additional relevant information | | | | | |
| Social History (eg. Employment) | | Special Needs (eg. Wheel Chair) |  | Phobia  Yes | No |

Please enclose any pertinent photographs where available

Triage Stamp

Date

Signature of referring doctor (or other professional)

(Legible Please)